

Health Development in Bangladesh

by Dr. Khalilur Rahman

The development efforts in Bangladesh have been undermined by the incidences of poverty, population growth and environmental degradation. These elements are closely interlinked and their adverse impacts on health are notorious.

HEALTH development is closely associated with the overall development process of any nation. Centrality of health in all development processes has been recognised by all. Role of health in development was also recognised by the UN.

The UN General Assembly adopted a resolution (No. 34/58) wherein it termed "health as an integral part of development". The Health For All (HFA) movement launched by the 30th World Health Assembly, considered health a basic human right and a worldwide goal.

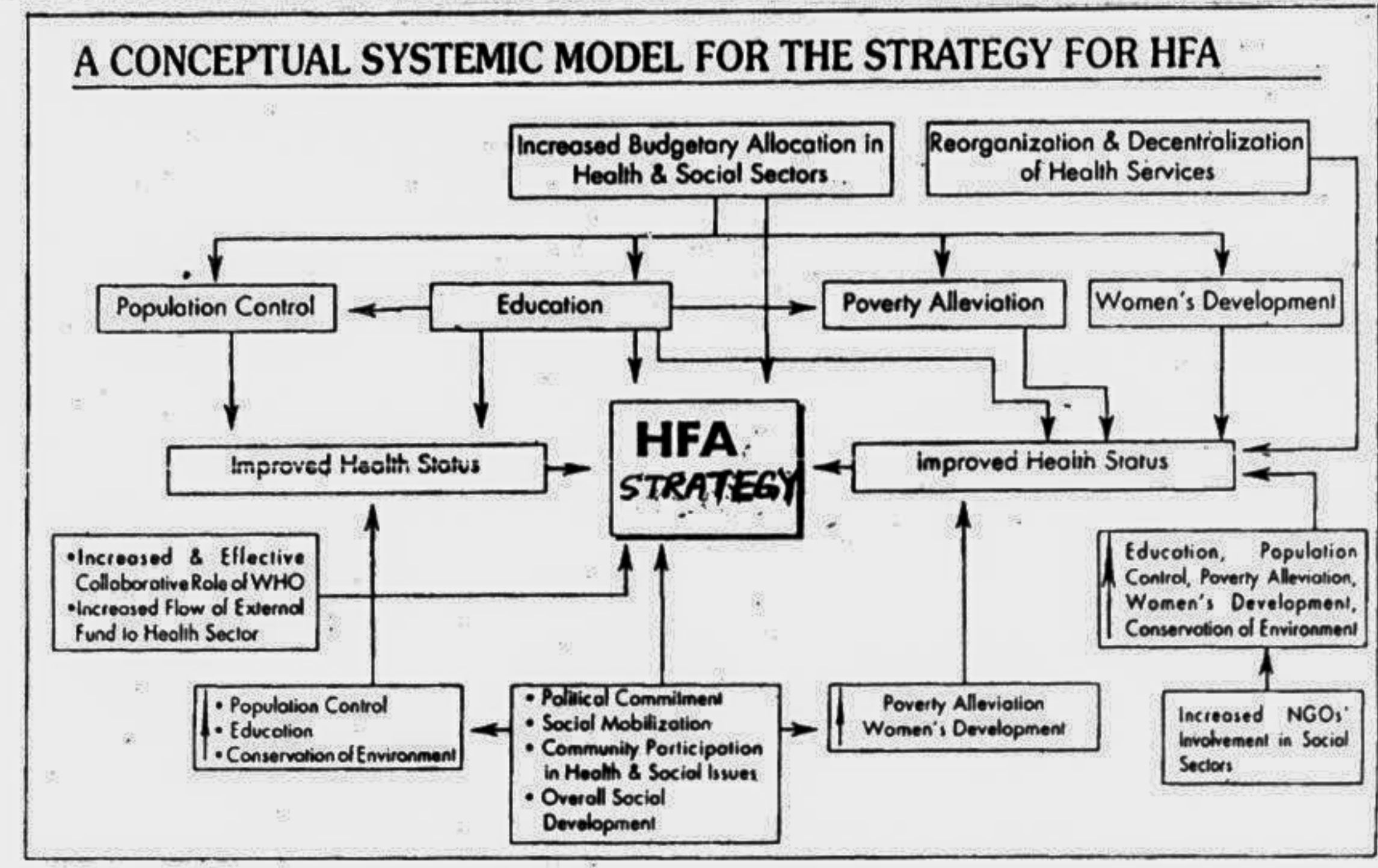
Bangladesh became member of the WHO in 1972, even before her membership to the UN. Since her joining this world body for health, she has been trying to improve the health status of her population.

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The end result of all this is that the health of the entire population is being affected. The process is also leading to economic insecurity resulting in high birth rate. Thus the cycle is revolving.

Increase in literacy rate and in primary school enrolment has been found to be strongly associated with more rapid increases in per capita incomes and with greater economic equality. The education status of the people in Bangladesh is low, particularly among young girls, women and the poor.

Low status of education among women has contributed to their low status in all walks of life in the society. Their empowerment, right to reproductive health and gender inequity is greatly affected by their low education status.



contribute to economic growth and overall development of any society.

WHO, in collaboration with the World Bank, documented the importance of investing in health and identified that interventions to promote women's health as being the most cost-effective.

Despite relentless efforts by the successive Governments, the health system in Bangladesh could not still provide minimum health care services to the population.

Bangladesh is virtually caught in a "vicious cycle" of poverty, population growth, environmental degradation and illiteracy. This cycle needs to be broken not only for the improved health status of the population; but also for the overall development of the entire country.

The most important problem in Bangladesh is perhaps our large population. While we blame on poverty as the root-cause of ill health and diseases, large population is mostly responsible for poverty situation in the country.

mass extinction, an event not seen since the disappearance of the dinosaurs 65 million years ago," says John Tuxill, the author of the study.

make our country a prosperous one. There is an urgent need to raise the educational level of the entire population.

Education, in particular to women, could reduce population growth rate and provide better health care and nutrition.

Environmental degradation is closely related to poverty, education level and population growth. Unless poverty is reasonably alleviated, population growth rate is contained and literacy rate is raised, environment cannot be preserved and improvement in health sector cannot be ensured.

NGOs in Bangladesh have been involved in social development. The success of some NGOs in our country has been widely acclaimed both home and abroad.

Limited resource is another important obstacle to health development in Bangladesh. An LDC like her depends much on external financing for her development efforts.

quired for the improvement of health sector.

Moreover, the Government needs to initiate measures for alternative financing for health care services.

Predictable and sustained external financing is to be ensured for our overall development. We need to remind the donors and the international community about their commitments made in various international conferences.

As stated earlier, health development is an integral part of overall development efforts. Back home, a number of UN bodies and international agencies are working in various areas in support of the Government efforts in progressing overall social development of the country.

WHO's HFA Strategy is a co-ordinated programme for health development. Government is also aware of this fact. What is needed now is to implement this strategy.

The writer is Counsellor in the Bangladesh Permanent Mission, Geneva. Views expressed in this article do not reflect any Government's position.

Will Equity in Health Work?

by Dr M Zakir Husain

All civilised societies acknowledge health as a basic human right just as education is. Just as to deny education is a sin so is the act of depriving anyone of access to health care for whatever reason. Health is as basic as the right to life, Yet, health inequities persist and even get worse between countries and within countries.

SOCIAL inequities are as old as human societies. I would like to propose that equity in health is not only achievable and largely non-controversial, but also may help reduce other forms of social inequities.

But wherefore the idea of removal of health inequity arise? First, all civilised societies acknowledge health as a basic human right just as education is a sin so is the act of depriving anyone of access to health care for whatever reason.

The very word equity means different things to various schools of thought. But suffice it to say that it means, at the least for the present discussion, equal access to essential health care irrespective of anything to the contrary.

No doubt, there will be resistance to such a shift from those who are used to more, but the writer would believe the resistance will be less than what will be for shift of income directly to the poor from the rich.

We know there are existing inequalities of access to, or possession of, resources or other means of production; there are subtle and harsh forms of class inequality; free market allows more to flow to where there is

already more. The affluent consume many times more than the poor and needy. But does that necessarily get the rich more health security? I believe not or at best only a temporary and uncertain sense of security.

Disease agents travel without any regulation; need no visa to cross country borders nor to cross class boundaries. If for no other reason, there is enough to support equity in health care by the society for the security of all and enlightened self-interest of its affluent class.

Now, if there is merit more than moral reason in health equity, how to bring it about? First, let us get clear of academic or semantic controversy about the meaning of equity.

Now, we are under a regime of market economy and structural adjustment. The state is being "downsized", some are saying it actually is "right-sizing". Whatever it is, the state is withdrawing from public financing of health; the private market is getting prominent.

Is it equitable? No it is not. Whatever else, private health care market is notoriously inequitable. But then what can be done? The public sector in health is already poorly financed; it will be even more starved of funds with time as costs go up and budgets come under scrutiny.

But that will compel the

public sector to start collecting charges which the very poor will not be able to pay. Those who can pay may not do so for services they feel are irregular and of low quality or inconvenient. But this writer would argue the situation need not be as sceptical or grim as it appears to be.

First, there is no need for the government or voluntary non-profit agencies to withdraw from the market. There is need for them to select priorities and make meaningful and transparent partnership with the clients and among themselves.

There is need to put more resources into primary care especially at the remote and peripheral health facilities that are closest to the population in need (for rural as well as urban poor) yet are ironically the most neglected or under equipped and under financed.

Is it any surprise that the corollary of doing all these will be intelligent and courageous reallocation of resources - more for services that protect equity and less for services that work against equity - for example away from expensive tertiary care for the few that gives low net health outcomes.

Can the profession or the custodians of liberal society condone and congratulate the perpetuation of existing inequities? Rather than engage in leisurely and sterile academic debate on the definition and description of social inequities, is it not time to do something in

practice and begin to learn lessons that are to be learnt?

As stated before, I am aware of the fact that with persisting inequities in income, assets and access to other means of production, education, shelter, compounded by class and cultural barriers, there is no health "utopia" in sight anywhere or anytime soon, if ever.

Even a Kernalist revolution may fall a little short of what is needed to attain full literacy in early next century. This writer does not belittle the need for financial investments but would like to suggest that without full and bold commitment by the state and the society and without the "sacrifices" of the affluent and the privileged - willing or enforced - social goals as fundamental as equity will remain distant.

Yet, it seems that the reduction of health inequities may indeed be a less difficult task. The infrastructure is there, the means and methods are affordable and available, less commotion and clash of interest is at stake, and a responsible private and non-profit voluntary sector may even lend a helping hand. Hopefully this can happen. And when there is equity in health it may generate enough evidence of a success story to inspire, who knows, perhaps a thirst for other success stories say in education.

The creative energy released by health equity may well create the confidence needed to go through few other difficult reform processes in the society as a whole. For let us all hope that a healthy population with creative energy and self-confidence is the most precious asset and a powerful engine for change of the society.

India's Male Sex Workers Come out of the Shadows

Ranjita Biswas writes from Calcutta

In Indian society, male prostitutes live in a shadowy world and the subject is never mentioned in genteel circles. Yet, according to a report by the Panos Institute of London, there are 50,000 male prostitutes in the western metropolis of Mumbai alone.

SUNIL Das, who once lived on other people's verandahs, could not have imagined in his wildest dreams that he would one day visit picturesque Switzerland.

But Das did, this summer. A male prostitute from the eastern Indian metropolis of Calcutta, the dark and diminutive Das, his eyes lined with kohl was in Geneva to participate in the 12th World AIDS Conference which was attended by an estimated 13,000 international delegates.

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Das and Sonu went as part of a delegation that mostly

comprised women sex workers from Sonagachi, the largest red light area in Calcutta. Komal Gandhar, a cultural group from the area named after a note in Indian classical music, presented a dance drama at the inauguration ceremony of the conference.

The DMSC has conducted an HIV/STD intervention programme initiated by the All India Institute of Public Health and Hygiene and workshops on law governing their profession and demand for legalisation of their trade.

Though the Sonagachi programme is seen as a model for project planners in intervention programmes among sex workers, no one noticed one omission: male prostitutes. The DMSC members themselves were taken aback when male sex workers approached them for membership.

Das is now a peer worker and like women peer workers helps in popularising the use of condoms. Sarkar, however, claims that male sex workers always practise safe sex and condom use is the norm rather than the exception among them.

female counterparts in the larger social context: exploitation, confinement to the fringes of society, sense of personal loss and alleged harassment by the police.

In fact, our case is worse. At least the society accepts, though covertly, that there are women in the sex trade," laments Madhu Sarkar, the 28-year-old leader of the group who also happens to work in the film industry and is a dancer.

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Talking about people of his ilk, Das says softly: "We are human beings too and care for our families. I look after my widowed mother. She has now accepted my profession. At least the days of starvation and shifting from one verandah to another with landlords treating

you like dogs are over. I have even bought a TV set and my mother can enjoy her free time watching it."

Lambasting society for its hypocritical standards, Sarkar says that among their clients were doctors, engineers, professors, businessmen, many of them householders with children. The feeling of insecurity among male sex workers is high, he says, because "when we get picked up from a restaurant or from near a cinema hall near Chowringhee (downtown Calcutta's business district) we really don't know how the client will behave in the isolation of his premises."

He tells harrowing tales of inexperienced male prostitutes being abused and thrown out of the house by the client without being paid. Another problem is the constant police harassment, "though many in the force are our clients."

Yet, Sarkar finds it heartening that, thanks to the DMSC, they have now "come out of the shadows". Future plans include establishing an interactive centre where others can drop in and discuss their problems and expert help could be sought on health issues.

—India Abroad News Service

Drink of Death?

MILLIONS of cans of fizzy drinks and bottles of sparkling water have been withdrawn from sale in the UK because of fears that they could contain traces of the cancer-causing chemical benzene.

The company, Cadbury Schweppes has withdrawn its bottled Malvern sparkling water following reports that the water contained benzene levels of 10-20 parts per billion (PPB). Other well-known brands including Lilt, Coca-Cola, Fanta and Sprite have also been withdrawn from the market.

The World Health Organisation has recommended safety limit for benzene as 10 PPB. SmithKline Beecham, the manufacturer of the brands Lucozade and Ribena, is testing its products. It will await the results before deciding the future action plan.

Rob Hayward, chief executive of the British Soft Drinks Association said that the benzene originated as a contaminant in carbon dioxide manufactured by Terra Nitrogen, a UK-based company, which supplies a majority of the soft drinks in Britain.

Disappearing Act

AN estimated one of every four species of the world's vertebrates - mammals, fish, amphibians and reptiles - faces sharp declines in numbers or possible extinction, says the Worldwatch Institute, Washington, USA. "We are in the midst of

Compressed to Cool

ALTHOUGH CFCs and related chemical are being phased out as they damage the ozone layer, it has been difficult to find a replacement for them in car air conditioning. Daimler-Benz, Germany's automobile giant, is now testing an air conditioner that uses compressed carbon dioxide instead.

The gas was used in the earlier refrigerators, but abandoned since it needs very high pressure. However, with modern materials, this is no longer a problem.

Assam Town Reports Bizarre 'Telephone Death'

LITTLE did 25-year-old Jayaprakash know when he advanced towards the ringing phone to lift the receiver that it would be the last time he was doing it.

A moment after he picked up the receiver, Jayaprakash, who had just walked into his home at noon for his lunch, dropped dead. He was reportedly electrocuted, a newspaper has said.

Apparently, Jayaprakash was not the only such bizarre case in his neighbourhood of Gohpur in Tezpur, a town in the northeastern Indian state of Assam. About the same time, people in other homes in the neighbourhood who had lifted their ringing phones were injured, apparently because of the high voltage current passing through the instruments. The

Assam Town Reports Bizarre 'Telephone Death'

Indian Express reported.

The Assam Police and officials of the state telecom department, alarmed by the curious incidents which occurred late last month, are trying to probe the matter.

However, telecom officials have been postponing investigations as tempers are running high in the Gohpur area, the paper said. "People are very angry and we are scared to go (there). We can make investigations only when we get police escort," they were quoted as saying.

Mahendra Kumar Aggarwala, who reportedly sustained 40 per cent burns after he received a shock from the telephone receiver, told the paper: "That day (July 25), the telecom staff were working on some ca-

Assam Town Reports Bizarre 'Telephone Death'

ble fault when the electric wire (overhead high-tension line) carrying 11,000 kilo volt of current snapped and touched the main telephone line. All telephones in the area started ringing and whoever picked up the receiver was injured."

The overhead wire was finally removed by one of the telecom department employees with the help of a bamboo pole, Aggarwala added.

However, the Chief General Manager of the state telecom authority, who was not named by the paper, denied that Jayaprakash had died of electric shock from his telephone instrument. "There could be a local fault which could have given a mild shock but nobody has died from current flowing through them (telephone

Assam Town Reports Bizarre 'Telephone Death'

lines)," he said.

"For a person to die of electrocution, a current measuring at least 150-200 volts is required to pass through the heart," the Chief General Manager said, "while telephone wires can carry a maximum of 50 volts."

"Telephone instruments cannot survive such heavy current. If there is a strong current, the equipment at the exchange will catch fire and melt first," the manager was quoted as saying.

Also there is no question of all 162 telephones in the area ringing simultaneously because a rack contains only eight to 16 lines and only those will ring," he added.

—India Abroad News Service

